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2.4530 Medical Education Addition to Rates

For hospitals with medical education costs, the group payment rates were modified as follows:

Hospital Specific Rate = Group Payment Rate + Hospital Specific Medical Education Rate

The hospital specific medical education rate has two components, direct medical education (DME) rate and indirect medical education (IME) rate. These were computed as follows:

$$\text{Direct Medical Education Percent} = \frac{\text{Total Direct Medical Education Cost}}{\text{Total Cost for the Hospital}}$$

$$\text{Indirect Medical Education Percent} = 1.89 \times ((1 + \text{ratio})^{0.405} - 1)$$

$$\text{Hosp. Specific Medical Education Rate} = \text{Group rate} \times (1 + \text{DME Percent} + \text{IME Percent})$$

2.4600 DRG Daily Rates

The Department computed DRG daily rates for all DRG classifications. These rates will be used for computing reimbursement in cases involving day outliers, transfers, and eligibility changes (see subsections 2.5300, 2.5400, and 2.5600).

2.4700 Hospital Specific Medicaid Cost to Charge Ratios

The Department established a cost to charge ratio of Medicaid utilization of inpatient services for each hospital. This ratio shows a comparison of Medicaid reimbursable costs of general hospital inpatient services with the corresponding covered charges.

Cost to charge ratios (CCR's) were calculated using the cost reports submitted by hospitals and charge data from the claims database used to compute the DRG weights and hospital group rates.

These ratios will be used in the DRG reimbursement system to estimate costs of claims for determining whether the claims meet the cost outlier criteria (subsection 2.5110), and also to compute payment for cost outliers (subsection 2.5310). Please note these ratios should not be confused with the cost to charge ratios of various ancillary service departments computed in hospital cost reports.

2.5000 Determination of Payment Under the DRG Reimbursement System

This section provides policies and methodologies for the determination of payment in various situations under the DRG reimbursement system.

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2.5100 Identification of Outlier Claims

Each claim that is eligible for an outlier payment, will be tested to determine whether it meets the cost and/or day outlier criteria. If the claim does not qualify as either a cost or a day outlier, the standard DRG payment will be made to the hospital, unless the claim falls under one of the categories discussed in subsections 2.5400 through 2.5720 and another method is used for computing payment.

2.5110 Testing for Cost Outlier

The covered charges on the claim will be multiplied by the pre-established Medicaid cost to charge ratio for the hospital (subsection 2.4700) to estimate the cost of the claim. If the estimated cost is higher than the cost outlier limit established for the DRG which has been assigned to the claim, a cost outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5120 Testing for Day Outlier

If the covered length of stay on the claim is higher than the day outlier limit established for the DRG that has been assigned to the claim, a day outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5130 Example of Testing for Outlier

Data

Hospital Data:	Group Payment Rate	$ 2,836
	Cost to Charge Ratio	.78
Claim Data:	Covered Charges	$39,760
	Covered Length of Stay	50 days
DRG Data:	DRG Weight	4.2294
	Cost Outlier Limit	$32,899
	Day Outlier Limit	67 days
	Daily Rate	$ 503
	Adjustment Percentage	.75

Computation/Comparison

Testing for Cost Outlier:

Estimated Cost of Claim	=	Covered Charges	x Ratio
	=	$39,760	x .78
	=	$31,013	

Compare With Cost Outlier Limit $32,899

Testing for Day Outlier:

Covered Length of Stay	50 days
Compare With Day Outlier Limit	67 days

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2.5130 continued

Analysis

Cost Outlier: The estimated cost of the claim ($31,013) is less than the cost outlier limit ($32,899). Therefore, the claim is not a cost outlier.

Day Outlier: The covered length of stay on the claim (50 days) is less than the day outlier limit (67 days). Therefore, the claim is not a day outlier.

2.5200 Standard DRG Payment

Standard DRG amount will constitute the base payment for an inpatient discharge except in those situations where a partial payment may be made. Any outlier payment for the qualifying claims will be in addition to the standard DRG payment.

Standard DRG amount for a claim can be obtained by multiplying the relative weight of the DRG assigned to the claim, by the group payment rate assigned to the hospital.

Example of Standard DRG Payment Calculation:

Referring to the data in subsection 2.5130:
Standard DRG Payment = DRG Weight x Hospital Group Payment Rate

= 4.2294 x $ 2,836
= $11,995

2.5300 Payment for Outlier Claims

If a covered general hospital inpatient stay is determined to be a cost or day outlier, the total reimbursement will consist of the standard DRG payment plus an additional amount for the outlier portion of the claim.

2.5310 Cost Outlier Payment

The payment for the cost outlier portion of a claim will be obtained by multiplying the difference between the estimated cost of the claim and the applicable cost outlier limit, by the DRG adjustment percentage. Cost outlier payment will be made for up to 360 inpatient days of stay, beyond which only day outlier payment will be made.

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2.5310 continued

Example of Computing Cost Outlier Payment:

Data

Hospital Data : Same as subsection 2.5130
Claim Data : Covered Charges....$45,980
DRG Data : Same as subsection 2.5130
Standard DRG Payment: $11,995 (from subsection 2.5200)
Assumption : Not a day outlier

Computations

Estimated Cost = Covered Charges x Hospital Ratio
= $45,980 x .78
= $35,864

Payment for Cost Outlier Portion = | Estimated Cost - Cost Outlier Limit | x DRG Adj. Percentage
= ($35,864 - $32,899) x .75
= $ 2,224

Total Payment = Std. DRG Pymt. + Outlier Pymt.
= $11,995 + $2,224
= $14,219

2.5320 Day Outlier Payment

The payment for the day outlier portion will be obtained by multiplying the difference between the covered length of stay and the applicable day outlier limit, by the DRG daily rate and the DRG adjustment percentage.

Example of Day Outlier Payment Computation:

Data

Hospital Data : Same as subsection 2.5130
Claim Data : Covered Length of Stay.....73 days
DRG Data : Same as subsection 2.5130
Standard DRG Payment: $11,995 (from subsection 2.5200)
Assumption : Not a cost outlier

Computations

Payment for Day Outlier Portion = | Covered Length of Stay - Day Outlier Limit | x DRG Daily Rate x DRG Adjustment Percentage
= (73 - 67) x $503 x .75
= $2,264

Total Claim Payment = Standard DRG Payment + Outlier Payment
= $11,995 + $2,264
= $14,259

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2.5330 Simultaneous Cost and Day Outlier Payment

If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the reimbursement will be the greater of the amounts computed for cost outlier and day outlier.

Example of Payment for Simultaneous Cost and Day Outlier:

Data

Total Claim Payment for Cost Outlier...$14,219 (subsection 2.5310)
Total Claim Payment for Day Outlier....$14,259 (subsection 2.5320)

Analysis

The higher of the two amounts, $14,259, will be the reimbursement amount for the claim which meets both cost outlier and day outlier criteria.

2.5400 Payment for Transfers

When a recipient is transferred during a covered general hospital inpatient stay from one hospital to another hospital, the reimbursement to all hospitals involved in the transfer(s) will be computed as follows.

2.5410 Transferring Hospital(s)

The reimbursement to each transferring general hospital shall be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital shall be no greater than the standard DRG amount, except where the transferring hospital is eligible for outlier payments.

2.5420 Discharging Hospital

The discharging general hospital shall be reimbursed the standard DRG amount. If the claim qualifies as an outlier, the discharging hospital shall be eligible for an outlier payment based solely on the length of stay at the discharging hospital.

2.5430 Transfer To or From a State Operated Hospital

If the transferring hospital or the discharging hospital is a state operated hospital, reimbursement to the state operated hospital will be computed according to the methodology for state operated hospitals.

2.5440 Example of Payment Determination in Transfers

The following situation will provide an illustration of the various payment methods used when a patient is transferred from one hospital to another. Although the situation may not be realistic with regard to the medical treatment provided, it shows all basic payment methods for patient transfers through a single example.

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2.5440 continued

A patient is admitted to a state operated hospital (Hospital A), and after a stay of two days with $1,400 in billed charges, the patient is transferred to a general hospital (Hospital B). Hospital B has the patient for three days and the case is assigned DRG #186. Hospital B is in Group 2. The patient is then transferred to another general hospital (Hospital C) due to complications. The patient is discharged after six days from Hospital C, and is assigned DRG #186. Hospital C is in Group 1.

Payment to Hospital A: Since Hospital A is a state operated hospital, the payment will be determined using the methodology specified in the section on state operated hospitals.

Payment to Hospital B: Hospital B is a transferring general hospital, and will therefore be paid a DRG daily rate for each day of stay, with total payment limited by the standard DRG amount.

Data Used for this example:

DRG Daily Rate	$ 597
DRG Weight	.6515
Group 2 Rate	$2307

The transfer payment will be computed by multiplying the number of days times the DRG daily rate; i.e., 3 times $597, or $1,791. This amount will be compared against the standard DRG amount, and the lesser of the two shall be paid. The standard DRG amount is .6515 times $2,307, or $1,503. Therefore, Hospital B would be paid $1,503.

Payment to Hospital C: Hospital C is a discharging general hospital, and would therefore be paid the standard DRG amount plus any outlier payment, if applicable.

Data Used for this example:

DRG Weight	.6515
Group 1 Rate	$2766

The standard DRG amount is $1,802. If this claim had been a day and/or a cost outlier, an additional payment would be made.

2.5500 Payment for Readmissions

2.5510 Readmission to the Same Hospital

If a recipient is readmitted to the same hospital within 30 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; the reimbursement will be made only for the first admission.

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2.5520 Readmission to a Different Hospital

If a recipient is readmitted to a different hospital within 30 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; payment will be made only to the second hospital to which the patient was readmitted. Payment made to the first hospital for the original (first) admission will be recouped.

2.5530 Determination of Payment for Readmissions

Whether the reimbursement should be made for the first or the second admission (i.e., the original admission or the subsequent readmission), will be ruled by the discussion in the preceding subsections 2.5510 and 2.5520. The amount of reimbursement in each situation will be determined as provided in subsections 2.5100 through 2.5400.

2.5540 Federal Fiscal Year End Proration

The reimbursement for inpatient stays through Sept. 30 shall be computed using the DRG system components (group payment rates, outlier limits, DRG weights, etc.) in effect during that period. For services provided on and after Oct. 1 the payment amount computations shall use the system components effective Oct. 1.

2.5600 Recipient Eligibility Changes

If a recipient is determined ineligible for the Medicaid/MediKan Program for a portion of the inpatient stay, reimbursement shall be made to the general hospital only for those days of stay which were also days of eligibility. No reimbursement shall be made for services provided on days when a recipient was ineligible for the Medicaid/MediKan Program.

The payment amount will consist of the DRG daily rate for each eligible day during the inpatient stay in the hospital. No more than the standard DRG payment plus any outlier payment (if applicable), will be allowed as the total payment. Only the Medicaid covered inpatient days and charges will be used for outlier payment computation.

2.5700 Payment for Interim Billings

Hospitals will be allowed to submit interim bills for inpatient stays longer than 180 days. Each interim bill must cover 180 or more continuous days of service except the discharge billing and the federal fiscal year end cut-off billing, each of which may include less than 180 days as the situation may be.

2.5710 Payment for First Interim Billing

The first interim bill will be treated like any other claim, in the sense that it will be tested to determine if it meets the cost and/or day outlier criteria. If the stay covered in the first interim bill does not qualify as an outlier, only the standard DRG amount would be paid. If the claim exceeds the cost and/or day outlier limit(s), an appropriate outlier payment will be made in addition to the base amount.

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2.5720 Payment for Second and Subsequent Interim Billings

At the time of each interim bill after the first, an outlier payment amount will be determined using the cumulative cost and days since the date of admission through the last service date included in the current interim billing. One of the following two situations may occur:

Up to 360 Days: Up until 360 days of continuous staff, the Department will authorize the fiscal agent to pay the higher of cost and day outlier amounts for each interim bill.

Longer than 360 Days: When the stay becomes longer than 360 days, only day outlier payments will be made.

2.6000 Settlements and Recoupments

There shall be no year end settlements under the DRG reimbursement system. However, some settlements and recoupments may occur because of Surveillance/Utilization Review or other reviews which determine that payments were in error.

3.0000 General Hospital Reimbursement for Inpatient Services Excluded from the DRG Reimbursement System.

Reimbursement for heart, liver and bone marrow transplant services shall be excluded from the DRG payment system. Reimbursement for these transplants shall be based upon the lesser of reasonable costs or customary charges, contingent upon transplant surgery. An annual settlement shall be made. For services provided prior to the transplant surgery, or if transplant surgery is not performed, reimbursement shall be made according to the DRG payment system.

4.0000 Reimbursement for Inpatient Services in State Operated Hospitals

Reimbursement for inpatient services in state operated hospitals shall be based upon the lesser of reasonable costs or customary charges for covered services rendered to eligible individuals.

4.1000 Hospital Changing From a General to a State Operated Hospital

If a hospital changes from a general to a state operated hospital, claims shall be paid as shown below.

a) Patients admitted prior to the effective date of becoming a state operated hospital shall be paid as a general hospital.

b) Patients admitted on or after the effective date of becoming a state operated hospital shall be paid as a state operated hospital.

4.2000 Malpractice Costs in a State Operated Hospital

Medicaid malpractice cost shall be determined by dividing the risk portion of malpractice cost by total hospital charges and multiplying the result by allowable Medicaid charges. This shall be used for all cost report periods ending on and after 7/1/91.

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5.0000 Reimbursement for NF Services (Swing Beds) in General Hospitals

Reimbursement for NF services (swing beds) provided in general hospitals (swing bed hospitals) shall be pursuant to 42 CFR 447.280.

6.0000 Disproportionate Share Payment Adjustment

The Medical Assistance Program (Medicaid/MediKan) of the State of Kansas shall make a reimbursement adjustment for disproportionate share hospitals. The reimbursement adjustment for disproportionate share hospitals shall be made for hospitals eligible under either criteria contained in 6.1000 or 6.2000 below.

Hospitals to be eligible under either Option 1 or Option 2 must have at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State Plan, except where the hospital serves predominantly individuals under 18 years of age, or where nonemergency obstetric services to the general population were not offered as of July 1, 1988. In rural areas the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. Please see section 6.50000 for additional instructions.

6.1000 Option 1

If determined eligible for disproportionate share payment adjustment according to P.L. 100-203, Section 4112, Subsection (b)(1)(A), and the Medicare Catastrophic Coverage Act, (eligibility shall be determined for a maximum of one year per determination), a hospital shall be reimbursed for disproportionate share according to the following. The mean Medicaid/MediKan inpatient utilization rate for Kansas hospitals receiving Medicaid/MediKan payments plus one standard deviation shall be subtracted from each hospital's Medicaid/MediKan inpatient utilization rate. If the remainder is greater than zero, the remainder shall be divided by 2, 2.5% shall be added, and the result shall represent the percentage payment adjustment. This percentage payment adjustment shall be multiplied by the Kansas Medicaid/MediKan annual payment for inpatient hospital services made for the state fiscal year ending two years prior to the year of the administration of a disproportionate payment adjustment. For example, 1995 state fiscal year payment adjustment shall be based upon the state fiscal year 1993 Kansas Medicaid/MediKan annual payment. The mean Medicaid/MediKan inpatient utilization rate shall include Medicare days paid by Medicaid. In order to be eligible, the hospital must have a minimum medical utilization of 1%, as determined in Option 1.

6.2000 Option 2

Hospitals are determined to be eligible under the low-income utilization rate if, based upon the computations below, line C1 exceeds 25%. Hospitals shall be sent a form specifying the eligibility criteria prior to the start of each state fiscal year. Eligibility shall be determined for a maximum of one year per determination. Only hospitals returning the form may be potentially eligible for Option 2. This form shall be compared with the Medicare cost report (HCFA-2552-92), paid Medicaid/MediKan claims summary and other information as necessary in order to verify the data submitted.

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6.2000 Continued

All data below, except where specifically noted, should only include inpatient hospital data. SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory surgical center, hospice, or non-reimbursable cost centers shall not be considered. Although specific references are given to the Medicare cost report, other line numbers may also be applicable where the hospital uses a blank line and adds an alternative title to the forms.

A1. Medicaid/MediKan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payments.

A2 & A3. Other state and local government income from Medicare Worksheet G-3, Governmental appropriations (Line 23), excluding Disproportionate share payments.

A4. Total Medicaid/MediKan, State and local government funds (A1+A2+A3).

A5. Inpatient Revenues from Medicare worksheet G-2, Column 1, Total inpatient routine care services (line 16) + ancillary (line 17) + outpatient (line 18) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8).

A6. Total patient revenues from Medicare Worksheet G-2, Column 3 (line 25).

A7. Ratio of inpatient revenues to total patient revenues (A5 / A6).

A8. Contractual allowances and discounts from Medicare Worksheet G-3 (line 2).

A9. Inpatient share of contractual allowances and discounts (A7 X A8).

A10. Net inpatient revenue (A5 - A9).

A11. Ratio of Medicaid/MediKan, State and local government funds to net inpatient revenue (A4 / A10).

B1. Inpatient charity care charges, excluding Medicaid/MediKan, Medicare, contractual allowances and discounts.

B2. Other State and local government funds (A2 + A3).

B3. Ratio of inpatient revenues to total patient revenues (A7).

B4. Inpatient portion of State and local government funds (B2 X B3).

B5. Hospital costs from Medicare worksheet B Part I, total column, subtotal (line 95) - Ambulance (line 64) - DME (lines 65 & 66) - Medicare (line 69) - unapproved teaching (line 70) - HHA (lines 71 through 81) - CORF (line 82) - HHA (lines 89 & 90) - ASC (line 92)- Hospice (line 93).